JOHNSON (JOS. T.)

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MANAGEMENT OF THE THIRD STAGE OF ABORTION,

WITH RETENTION OF MEMBRANES.

BY

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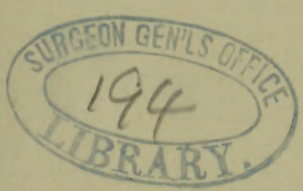
DISTRICT OF COLUMBIA.



EXTRACTED FROM THE

TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION.

PHILADELPHIA:
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ON THE MANAGEMENT OF THE THIRD STAGE OF ABORTION, WITH RETENTION OF MEMBRANES.

The main indications for the treatment of abortion are clearly enough set forth in our systematic treatises on midwifery in present use in our schools, and several points have recently been prominently discussed in obstetrical and gynæcological societies and medical journals relating to a better control of hemorrhage, and the necessity of greater care in the after treatment of women who have recently miscarried, as a means of prophylaxis against the occurrence of diseases requiring later on the services of the gynæcologist.

Playfair lays some stress upon this point, and declares that sufficient attention is not devoted to this very important item of treatment, and thinks it a frequent source of trouble on the part of patients who have miscarried.

To one acquainted with the more recent obstetric literature, the treatment of abortion is not especially a vexed question until he arrives at the stage which I have selected as the subject for discussion in this short paper.

In cases of too early rupture of the amnion, as the result of strong uterine contractions or too persistent digital manipulation, and a fœtus, say under the fourth month, is expelled; and the secundines are retained by the premature contraction of the internal os uteri, where little or no hemorrhage occurs; the patient is feeling comfortable, and no immediate danger seems impending—the *questio vexata* which needs authoritative solution is, what are we to do? What is the measure of our responsibility?

The patient and her family, reposing implicit confidence in the physician of their choice, rely confidently upon his advice and counsel at such a time as this. He is supposed to know the dangers, and is looked to for such treatment and suggestions as

will effectually ward off their approach, and restore the patient to her previous health, uninjured by their menacing presence.

We are expected to look into the future and see the liability of the occurrence of hemorrhage, placental polyps, subinvolution, uterine displacements, and their attendant evils. They cannot, and consequently trust to us to shield and protect them; and when it is advised that nothing further be done, that nature be trusted to expel in her own time and way, or perhaps to absorb, the contents of the uterus, they are well satisfied and pleased to be let alone, resting in the security of our counsel.

Patients thus managed pass too frequently from the care of their medical attendants as cured, only to return months thereafter with one of the above-mentioned ailments for treatment, or into the hands of another physician, who may or may not recognize the cause of the trouble. Should he in his diagnostic investigations come upon portions of retained placenta or partially putrid membranes, the chances are that the patient will lose confidence in the physician through whose neglect, ignorance, or inattention she has suffered so much pain, sickness, and expense.

Instead of the picture presenting itself in this light, hemorrhage, fetid discharges from putrid secundines, chills, fever, and septicæmia may early occur, and we may scarcely be able to save the life which we should never have allowed to be so seriously threatened.

I desire to discuss this question from the affirmative side, and to state as a general principle of sound treatment, that a woman is never safe until all matters connected with the pregnancy are expelled from the uterus, and that our chief indication for treatment is to cause their immediate removal.

The cases where the medical attendant should feel justified in leaving the house of a patient whose secundines are still in utero, should constitute very rare exceptions to the general rule, and in these instances antiseptic injections, carbolized tampons, and constant watchfulness should be observed to protect the patient against the sudden occurrence of hemorrhage or septicæmia.

To those who agree to the affirmative side of this question, the presentation of this subject at all may be a matter of surprise; and in order to justify myself in their eyes for bringing forward so stale a subject for consideration in this body, I feel compelled to state my belief that a large number of practitioners

throughout the country do not hold these views, or practice them in the treatment of their patients.

This is proved by a recent discussion of this very point in the New York Academy of Medicine, where a distinguished Fellow remarked, that "he was not only surprised, but a little shocked, to find so many men who were in favor of allowing the placenta, as a rule in those cases, to remain undisturbed."

The President of the Obstetrical Society of Edinburgh, in noting the recent improvements in Obstetrics and Gynæcology, said, in his inaugural address in November, 1879, "I may notice the great improvement of late years in the treatment of those troublesome cases of hemorrhage following abortion in early months, where part of the placenta and membranes is retained, and where the os is closed, so that a finger cannot be admitted, as not unfrequently happens, when by opening it up, by means of a sponge or tangle tent, so as to get access to the source of the bleeding and discharge, and removing this by means of the finger, or otherwise, we relieve the patient from a position of considerable peril."

Until recently, the general teaching of the text-books has been in favor of temporizing. As far as they gave any definite instructions, it was to the effect that, if difficulty was encountered in the delivery of the after-birth, or membranes, more injury was likely to result from the manipulation necessary for their removal than would occur, if it was left alone, and nature trusted to take care of it.

Angus McDonald, in a paper published in February, 1880, in the *Edinburgh Medical Journal*, states the case in very nearly opposite terms. He says: "I believe also that more harm is likely to result from under-caution than from undue interference in such cases; at least, experience has led me to believe that a *majority of our professional brethren* are more apt to err in this particular, through defect, than through excess of activity. The result is that their patients are liable to be landed in troubles that are much more serious than any dangers, real or imaginary, connected with a thorough evacuation of the uterus. To put it plainly, I believe a patient is put to greater danger from a portion of the membranes being left in the uterus, to become organized there, and a source of persistent menorrhagia, than one is likely to suffer from the manipulation necessary to secure complete removal of every part of the ovum in miscarriage."

Dr. J. Veit, of Berlin, recommends more active measures than the text-books to empty the uterus, in such cases of delayed abortion as threaten danger to the mother from absorption of putrescent portions of the embryo or its envelopes.

He gives an account of two cases where he was obliged to hurry the expulsion of the contents of the uterus on the sudden occurrence of rigor and high fever. The temperature rose to 105° in both cases. They were successfully treated by complete evacuation of the uterus, and antiseptic injections.

The clinical history of cases is better evidence than any amount of theory, and I therefore beg to recite briefly the history of four instances coming under my own observation, and presenting different phases for treatment.

Case I.—In October, 18—, I was called to see Mrs. ——. She had been under the care of a German midwife. I found that she had been delivered of a fœtus, at the tenth week of pregnancy, ten days previous to my call. Nothing unusual occurred during the labor. She lost no great quantity of blood; the fœtus had been clearly recognized in the discharges; no membranes came away; considerable ergot had been administered, severe pains were produced, but nothing was discharged from the uterus. She did well for several days. In about a week, however, the discharges became offensive, she had repeated chills, night-sweats, fever, furred tongue, high temperature, anorexia, and exhausting diarrhœa; no pain.

Upon my first visit, after learning these facts, I dilated the cervix, and removed a most offensive mass from the uterus washed out its cavity with antiseptic injections, and placed her upon a nourishing diet—iron, quinine, etc. Improvement dated from that hour. She made a slow, but perfect recovery, and I have since delivered her of two healthy children.

Case II.—In July, 1878, I was requested by my friend, Dr. Prentiss, to assist him in the management of a case of a lady who had three days previously aborted of a four months' fœtus. Notwithstanding the administration of about two ounces of Squibb's fluid extract of ergot, the placenta and membranes were still in utero. For two days little hemorrhage occurred, and the patient had felt as well as could be expected, except for the pains excited by the ergot.

The night previous to my being associated with the case, the lady had been seized with a severe chill, had high fever and delirium, with slightly fetid discharge. The immediate removal of the placenta was agreed upon. We gave ether, and at the request of the doctor, I passed my hand into the vagina, dilated the cervix by digital manipulation—though we had the Barnes dilators ready for use—passed two fingers into the uterus, which I pushed down into the pelvis with the other hand, applied externally, and removed the placenta. It was quite firmly attached to the walls of the uterus, and had to be taken away in small pieces.

The subsequent treatment was similar to that of the preceding case. The lady made a good recovery.

Case III.—In December, 1879, I saw Mrs. A., also in consultation with Dr. Prentiss. It was his opinion that she had been taking means for the production of an abortion. She was a little over three months advanced in her third pregnancy. The fœtus had been expelled before the doctor's connection with the case. This lady lost much blood previous to the delivery, during the labor, and after the expulsion of the fœtus.

I saw her on the evening of the third day; the placenta and membranes were still in the uterus; the patient was pale, very nervous, and weak from loss of blood; there was no foul odor to the discharges; pulse and temperature slightly above 100°; blood was constantly oozing away; the patient and her family were considerably alarmed for her safety. She had taken liberally of ergot, and the internal os would admit of only the tip of the examining finger. We hesitated to give ether in her weak state, but, fearing that the loss of more blood might prove fatal, finally administered it. She seemed to improve under its influence; and while the doctor made pressure over the abdomen, I gradually passed my hand into the vagina, and without difficulty dilated the cervix sufficiently to get the index finger through the internal os. The placenta was adherent in nearly all of its extent. I gently detached small portions of it at a time, removed all that I could, and with antiseptic injections thoroughly washed out the uterus. It contracted firmly, little, if any, hemorrhage took place, and the patient recovered, and has since been well.

Case IV.—Was called in the night hurriedly to see Mrs. P., March 24, 1880. She was flooding severely, and having regular labor-pains at intervals of ten minutes. She was a young primipara, and only six weeks pregnant. The os was dilated to the size of a five-cent piece, and the ovum could be felt protruding. Under the influence of ergot and vaginal tampons, the pains increased in rapidity and strength, and the fœtus was soon expelled. It was about the size of my little finger. I waited for the expulsion of the membranes; gave more ergot; the pains were excessively severe; she suffered from them much more than during the delivery of the fœtus. I finally tamponed the vagina and left for home, hoping it might be expelled during the night.

The next day I removed the tampon, and could distinctly feel the membranes high up in utero. She was feeling very well, and wanted to get up. I gave her more ergot, washed out the vagina with carbolized water, and put in a fresh tampon. The pains excited by the ergot were so distressing that the husband called upon me three times during the morning, urgently requesting that something be done to quiet his wife's sufferings.

In the evening I combined McMunn's elixir of opium with the ergot, and gave forty drops of each. The pains became so unbearable that I finally had to administer morphia to quiet her agony. She became absolutely uncontrollable, and in attacks of pain could scarcely be held on the bed.

In the mean time great sensitiveness had developed over the uterine region. She lay with knees drawn up, had dry, brown tongue, complete loss of appetite, night-sweats, chilly sensations up and down the spine. The pulse and temperature were not above 100. No more hemorrhage occurred; there was the faintest odor upon the finger after an examination.

On the morning of the third day a consultation was held at my request. The consultant distinctly felt the membranes through the os uteri, but on account of the tenderness about the uterus and pelvic tissues counselled against operative procedure, and advised the further use of ergot and the opium elixir.

Terrible pains were excited by the ergot. I allowed them to last several hours, but finally gave ¼ grain sulph. morphia and 30 grains bromide of potass. in a powder, and applied hot fomentations over the hypogastrium. I gave no more ergot.

The os uteri, under the contractions produced, was becoming

so small that I could scarcely get the tip of my finger through sufficiently to free the membranes. By firm pressure, however, on the fifth day after the expulsion of the fœtus I depressed the uterus and detached some small, partially decomposed masses.

Strict watchfulness was constantly observed. Antiseptic vaginal injections were used several times daily as long as any odor or discharge remained, and nothing more was done except to administer tonics and nourishment. She gradually regained her health, and in a month was riding out, and now looks well. She has menstruated twice since her recovery; at first the flow was black, thick, and offensive, but subsequently became clear and free from clots. There was nothing unusual noticed about her second period, and no hemorrhage occurred in the interval.

Nothing has ever been seen of the retained membranes. The injections and all discharges were carefully watched and inspected, and nothing resembling the masses removed by my finger has ever come away. They may have become liquefied and passed without the knowledge of the patient. They may be there yet. I think neither theory is correct. Nothing was observed to come away, and the menstrual flow is now natural in color and quantity, and painless.

Especial attention is directed to the unusual effect of ergot upon the circular fibres about the internal os uteri in some cases of abortion in the early months. The pains produced by its administration in the case just recited were simply terrible. The patient was only six weeks pregnant. The os, which had previously been sufficiently patulous to allow the admission of the first phalanx of the index finger, with which the mass of membranes could be distinctly felt, was under the influence of ergot completely closed, and remained so for some time afterwards. The very means used for exciting more powerful uterine contractions seemed to be the cause of the failure to effect their expulsion. The circular uterine muscular fibres near and about the internal os appeared to receive the effects of the oxytocic first, and when the fundus and body of the uterus contracted, the advance of the contained mass was resisted, and the pains were intensified and rendered of none effect. I have noticed this fact in other cases. Noegerath has reported similar effects of ergot in abortion, in the *American Journal of Obstetrics*.

With my experience the retention of a small piece of placenta or membrane has been accompanied by increased flow which

was more or less constant, sub-involution, frequently by displacement on account of its increased size and weight, and the various other symptoms which naturally result from such conditions.

I have removed several placentæ or parts of placentæ, and portions of membranes, months after a miscarriage, when the above symptoms had been observed. If the placenta is ever absorbed, this is possibly one of the cases.

This lady made a narrow escape. The error was in not persisting in the removal of the secundines immediately after the delivery of the fœtus. There probably would have been some difficulty in their complete removal, but the pain and the risk would have been *slight* in comparison to the agony which she suffered from the effects of the ergot, and the risks of impending anæmia and blood-poisoning.

I can readily understand how we might feel justified in permitting delay in some cases, when there is great nervous excitement or exhaustion. These might, perhaps, better be allayed or overcome by appropriate treatment, keeping a most careful watch, in the mean time, for symptoms indicative of trouble, and acting promptly should they arise. Hemorrhage might have been so excessive as to make delay for a short time the wiser plan. The added shock of immediate removal might better be delayed until reaction had set in.

The point which I wish to emphasize, and which this paper is presented to emphasize, is, that the patient is not safe until her *uterus is empty and firmly contracted;* and that it is the duty of the attending physician to see that these ends are accomplished before he leaves the case.

The President of the New York Obstetrical Society, in 1878, when this subject was being discussed, said: "The sooner the uterus is emptied, the sooner can the physician feel that the patient is safe. If the cervix is not dilated, which is rather a rare occurrence, and there is no hemorrhage, it should be dilated at once, and the placenta removed." If left behind, and serious trouble ensues, the responsibility should be placed upon the physician, who knowingly left this secret enemy lying in ambush ready to spring at any favorable moment upon the fair and trusting patient, poisoning her blood, devouring her strength, and perhaps killing her outright. A septicæmia once set up by the absorption of putrid material cannot always be relieved by its

speedy removal, and the vigorous use of antiseptics. It may be too late.

The general principle, then, of securing the complete and speedy removal of the contents of the uterus, and its firm contraction after abortion, I insist upon as the only safe practice. The rare exceptions demand the closest watchfulness.